HEROIN AND OPIOID EMERGENCY TASK FORCE MEETING

October 15, 2015, 1:00PM-3:45PM
Wineland Building, 16 Francis Street, Annapolis, MD

INTRODUCTION

- The **Lieutenant Governor** opened the meeting and turned it over to the Department of Juvenile Services.

DEPARTMENT OF JUVENILE SERVICES (DJS) (Jay Cleary, Chief of Staff)

- Juvenile complaints have declined significantly; complaints referred to DJS intake declined between 52% from FY2009 to FY2015
    - When it comes to intake, 90% of DJS intake is brought in by the police
- Referrals of youth with drug-related offenses have declined significantly
    - Overall drug offenses referred to DJS intake dropped almost 64% from 2009 (over 10,000 in 2009 to 3,626 in 2015); felony drug offenses declined 77.5% (2729 in 2009 to 613 in 2015)
    - This is primarily where we get our youth – substance abuse.
- Annual average detained population has declined significantly
    - Overall juvenile detained population declined 43% (416 in 2009 to 236 in 2015)
    - Predisposition ADP declined 39%
    - Pending Placement declined 53%
- Out-of-Home committed population has declined sharply in the past two years; down 23% since FY 2009. Population has declined by 21% in just the past year
    - Declines in committed population took longer because there was a bottleneck in getting kids into treatment quickly. Numbers start to go up in 2012; Secretary Abed put in reforms to move kids along faster and cut out bureaucratic hurdles to get kids into treatment. We are finally seeing the commitment numbers drop.
- Average annual probation caseload has declined significantly – 43% drop since FY2009
    - Those adjudicated delinquent but allowed to remain in community make up the largest population
- DJS screens for possible substance abuse at various stages of the juvenile justice process
    - Substance abuse screens are used at intake; at admission at a DJS detention facility; when ordered by court into care of DJS or to be placed on probation in the community
    - By court order, DJS may administer urine screens to test for presence of illegal substances
- Substance abuse treatment services: wide array, whole continuum
    - Home-based: least restrictive – evidence-based intensive family therapy programs. Cost-effective, with family building supports. Some of these evidence-based initiatives are incorporating drug treatment into regular family therapy so parents have tools to monitor their kids.
    - Community residential – group homes, foster care, independent living
    - Staff Secure Residential: intermediate care facility for addictions, DJS Youth Centers

    - Hardware Secure Residential – DJS's Victor Cullen Center (boys), J. DeWeese Carter Center (girls), Residential Treatment Facilities. For youth with public safety risk or risk of flight.
- What we see within our own population: lots of misdemeanor drug offenses, marijuana, opiates – they are very high-risk youth. We trained our medical staff on recognizing signs of overdose; Naloxone; enhancing screening instruments to see if we can elicit more information from the youth about home environment and use of drugs in that particular environment. All of our providers are feeling decline of population by half – this is a success story because we don't want to incarcerate every kid.
- **Dr. Michael Finegan**: For members of the Task Force, this is one of the more prominent areas of importance – where decisive action and rapid action need to occur. Goal in this meeting is to identify perspectives, but also to come away with some recommendations to act very quickly to avoid the further closing of programs and cutting of services to different things (i.e. transportation out of addictions programs, etc.). I have tried to understand the juvenile justice addictions problem from people in the trenches to see what's occurring when we look at the numbers. Adult addictions programs are exploding in the state with massive increase of numbers. But adolescent addictions programs are in profound trouble. In terms of your perspective of the role of DJS as a partner in assisting Marylanders with adolescents facing drug addictions, what do you see as your role and the importance of your role?
    - **Mr. Cleary**: When we have youth with treatment needs, we do assessments, treatment plans, and work with subject matter experts at our own headquarters. It's a matter of finding the right fit for the youth, whether high-risk or not. Private providers are the meat of our service continuum. Our role is to link families with services and provide services to youth in our custody with the goal of changing the youth's behavior.
- **Tracey Myers-Preston**: Are the outcomes of the children better with the reforms you're using?
    - **Mr. Cleary**: When you look at providers, recidivism rates are average. Our primary problem is marijuana for teenagers. Some kids do well in treatment programs and others don't (those who don't think they have a problem). There are new accountability system for case workers to make sure that if a kid isn't following a court order, etc., there are escalating sanctions all the way up to filing violation of probation and having a court intervene.
- **Lt. Governor**: In the screening process, what percentage of kids are coming in with opiates?
    - **Mr. Cleary**: I have to get you the data. Last week we have 43 in our care or supervision that are opiate-dependent out of 4,000 youth we have in custody or supervision.
- **Dr. Finegan**: If people aren't referred to you or getting arrested, there's nothing you can do about it. Looking at Wicomico County as an example, the question is the degree to which that county is reflective of the rest of Maryland. There has been a profound increase in drug-related arrests in Wicomico in 2014. From 2011, there were 11 juveniles arrested for drugs; in 2012, that number doubled to 22. In 2013, it increased to 29, and in 2014 it doubled again to 45. When we look at the number of arrests, not accounting for drug arrests – just arrest of juveniles in general, we're seeing increases. 2011: 413

juveniles arrested; 2012: 460; this dropped to 388 in 2013 and then has increased to 418. When you speak to the state's attorney who is primarily responsible for juvenile arrests in Wicomico, his perspective is that 70% of the juveniles are arrested, but the root cause of their arrest is drug use. Drug use is the most predominant factor in these youths being arrested. When you look at the state's attorneys and police officers, they're saying that drug problems are escalating significantly. Data from state police statewide: remove data from Baltimore City and look at what our state in general looks like. Baltimore City has 66% reduction in arrests; that can skew the results of what it looks like in Maryland as a whole. The problem with juveniles and drugs is significantly worsening. So we have to look at how to explain this profound reduction in numbers. Given this information from Wicomico, Sheriff Cameron indicated that he had some slight reduction in his county for juvenile arrests; in general, I don't know why kids aren't having a problem but adults and everyone else is having a problem with drugs.

  - **Lt. Governor**: Are those numbers for Wicomico all drug arrests?
  - **Dr. Finegan**: I have "just drug" arrests and also "other/total arrests."
  - **Lt. Governor**: what is the profile of the teenage drug user? The drug of choice may be marijuana that can progress to heroin; but when they say "drugs," it can be any drug – marijuana or heroin.
  - **Dr. Finegan**: Right. 27% of all high school students in 2013 had been affected by drugs. The marijuana of today is ten times more powerful than before.
  - **Lt. Governor**: I understand that marijuana can be a gateway drug.

- **Dr. Finegan**: If DJS's goal is for youth to have successful lives and they're saying the primary root of their criminal behavior is drugs, but you're saying these numbers are significantly down, we have to figure out what the disconnect is. Wicomico County: "every juvenile arrested is formally charged. DJS is not going to move forward with these kids." Children with more family resources (intact, pushing hard for kids to be involved in academic process to become somebody) versus children who are without (only has DJS)
  - **Lt. Governor**: This puts DJS in a very difficult situation. There is also a push not to "lock up kids." There's a push from the public against this. Maybe this is more a social services issue and there should be a handoff.
  - **Dr. Finegan**: I think the data is very clear that we want to avoid putting kids into residential treatment programs and avoid putting them behind the fence. We know that in general that creates more problems. We're talking about the group in outpatient care (before we get them into prison, intervene). DJS, from many people's perspectives, is the only system that has the ability and resources to take care of these kids.
  - **Lt. Governor**: This is something we should take up in our workgroups in terms of how to approach it. This is not in DJS's mandate at this particular time. This is not just DJS. Bring in social services and other entities that are involved. Workgroups can look into this and look at the underlying factor of family.
- **Linda Williams**: Hopefully there are more diversion programs out there, like teen court. I would rather see diversion programs.
- **Dr. Finegan**: We have outpatient programs that will close before December. I want to facilitate ideas with Jay.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE (DHMH)

Michael Baier, DHMH Overdose Prevention Director and Kate Jackson, PDMP Manager: **Update on Recommendations for Mandatory Registration or Use**

- House Bill 3 from the 2015 legislative session would have mandated a check of PDMP – a broad mandate for prescriber/dispenser use. It received an unfavorable report by the Health and Government Operations Committee, though. As a result, Chairman Hammen requested a PDMP Advisory Board review of feasibility/desirability of mandatory use (currently in draft, due December 1). The Chairman also requested a PDMP "roadmap" for mandatory registration/use from DHMH/PDMP (distributed to Task Force on October 15). This document contains components of what it would take to map the smoothest transition to mandate.
- PDMP Overview/Background
    - Created in October 2011 and went operational in 2013 – turned on access to healthcare providers.
    - Administered by DHMH BHA
    - Requires electronic reporting of CII-V CDS dispensed in MD within 3 business days.
    - Healthcare provider access through CRISP Patient Query Portal (statewide HIE) for treatment purposes.
    - Law explicitly states providers NOT required to use PDMP.
- Clinical user stats: 13,240 total registered clinical users, including prescribers, prescriber delegates, and dispensers and dispenser delegates; averaging 21K patient queries per week. Many are in hospitals; ambulatory; pharmacy; long-term care small portion.
- Advisory Board Draft Recommendations
    - Overarching concerns: importance of stakeholder involvement at all stages of planning; steps to avoid chilling effect on legit prescribing
    - Phased implementation of 1) mandatory registration and 2) mandatory use
    - Issues to address before use mandate takes effect
        - Streamline user registration process
        - Educate providers about PDMP and its use
        - Support provider workflow integration
        - Improve system capacity (IT & administrative)
        - Improve data quality
- Mandatory Registration vs. Mandatory Use
    - Mandatory registration requires all CDS prescribers (and possibly dispensers) to have PDMP user accounts. Equips providers to query patient data but does not require that they do so
    - Mandatory use requires providers to query PDMP under certain specified circumstances; possible disciplinary sanctions for failure to query. May include requirement that prescribing decisions be informed by PDMP data review. Use mandate may exist without universal registration
- Board recommendation: mandatory registration – importance of preceding mandatory use
    - Ensure providers that fall under use mandate have ability to access PDMP data
    - Registration process is opportunity to educate providers about opioid misuse/addiction; role of PDMP and legal requirements

    - Providers receive basic training/education on how to access and interpret data in CRISP. Currently there's a training video but this is very important so they can better integrate into their workflow
    - Reduce possibility of unintended consequences from providers changing Rx practices based solely on desire to avoid burdensome registration process
    - Mandatory registration components
        - Legal: change law to require prescribers/dispensers to register with PDMP. Possible link to state CDS permit or health professional license
        - IT/Administrative: auto-register practitioners; utilize identity verification software to active accounts; link CRISP registration system with DDC/licensing board databases for automated verifications
- Provider education campaign
    - Include updated provider education module as component of registration process
    - Possibly tie education module to CDS permit
    - Presentations/outreach in partnership with professional societies
    - Education should address benefits and use of PDMP; how to interpret data; how to access community resources for behavioral health treatment and recovery supports, how to address potential diversion, how to address inadequate pain management.
- Provider workflow integration
    - Legal: PDMP law only allows for licensed practitioners to be prescriber/dispenser delegates. Change PDMP law to allow prescribers/dispensers to delegate unlicensed medical staff (medical assistants, ER scribes, etc.)
    - IT/Administrative: develop CRISP delegate management dashboard for prescribers/dispensers; expand hospital/health system EHR "single sign-on" integration with CRISP; consider supporting/mandating integration of PDMP data feed into hospital/health system EHRs; consider integration with eRx software
- Improve system capacity
    - Invest in CRISP IT infrastructure to support increased request processing. This is a big issue if we are going to have more and more queries.
    - Expand CRISP/PDMP administrative staff for end user support and policy/practice questions – for people who are asking about access, how to get information, etc.
    - Work with MHA/hospitals to address local network problems that inhibit CRISP access – may be a hospital by hospital issue
    - Implement/test CRISP's Mirth query portal update (Jan-July 2016) – pretty large update. If all goes well, this may address system capacity issues. But CRISP is piloting this so there may be some unintended hiccups.
    - Continue to enhance data display options in CRISP including other state's data and MED calculator and other clinical support tools.
- Address data quality issues
    - Background: CRISP record matching has been an issue, but improvements made. Most data issues NOT result of IT problems. Primarily a "garbage in" problem – dispensers reporting inaccurate/incomplete data that is passed on to users.
    - Solution: expand PDMP administrative staff to improve data quality by:
        - Following up with dispensers on error reports to ensure resubmission

        - Monitoring and addressing non-"fatal" reporting errors in dispenser reports
        - Following up on increased user-identified data issues
- Mandatory use
    - Change PDMP law to require prescriber/dispenser use
    - Board recommends "pilot" mandate focusing on high-risk prescribing settings, including emergency departments, pain management clinics, opioid treatment programs, workers' compensation providers
    - Ensure non-compliance penalty in mandate
    - Create enforcement process with Boards/DDC
    - Expand mandatory use to wider provider groups post "pilot"
- Timeline
    - Mandatory Registration: IT development/CRISP infrastructure (8-10 months). PDMP operations/staff capacity building (8 months)
    - Mandatory Use: IT development/CRISP infrastructure (depends on IT projects funded and implemented). PDMP operations/staff capacity building (pilot 6 months, full use mandate 12 months).

Questions

- **Lt. Governor**: Registration versus use: CRISP times out after 90 days, so you have to readjust that, don't you?
    - **Kate Jackson**: It times out after 90 days of inactivity.
    - **Lt. Governor**: If they're not required to use it, it's going to sit there for some time and you have to adjust CRISP to account for that, right?
    - **Michael Baier**: You don't have to go through the entire registration process again; just have to call CRISP. We will need to look at this.
    - **Lt. Governor**: What kind of staff do you need to build up?
    - **Ms. Jackson**: PDMP staff: at minimum 2 full time staff members. 1 would be a programmer doing a lot of data programming and analysis and creating reports; 1 as an admin officer as project administrator taking data and results and engaging with end users (registrants or dispensers). From CRISP side, they can be temporary contractors, like a year or two. From PDMP side, this is ongoing.
- **Ms. Williams**: CRISP is the pharmacist?
    - **Mr. Baier**: CRISP is a statewide information exchange where hospitals exchange information. They have a website where a patient can be queried to see if a drug should be prescribed or not.
- **Ms. Myers-Preston**: Is PDMP working well? When it's working well, how well is it achieving?
    - **Mr. Baier**: There have been glitches along the way, but from providers that have been using it, it is unanimously appreciated. People have found the data useful and surprising.
    - **Ms. Jackson**: We have not surveyed clinical users very often, but we are creating focus groups about work flow, etc.
- **Ms. Myers-Preston**: If someone gets flagged, who gets contacted? What's the process?
    - **Mr. Baier**: The program itself has very little authority to analyze data and do anything with it. We're not really set up to analyze data, flag anyone; it was not contemplated when law originally passed.

- **Ms. Williams**: Are doctor-hoppers trying to get medicine for themselves, or are they looking to sell?
    - **Mr. Baier**: There's a range. When we look at our data now, some individuals are going to 40+ prescribers (diversion). People who meet lower thresholds may be at higher risk – this is what data from other states show.
- **Lt. Governor**: Registered active users – what is the universe? How many could come on the system if you made it mandatory?
    - **Ms. Jackson**: 35,000 total individuals
- **Dr. Finegan**: I commend you. Have database where providers can say how to improve the system.
- **Lt. Governor**: Similar to what we do when we get federal IDs, you have to go through video training to answer questions. This can be done for a person who's going to get access that's not necessarily a medical professional. The person who's there can get access because they're handling personally identifiable information.

PANEL 1: WORKERS' COMP

Brett Lininger - Chesapeake Employers' Insurance
Carmine D'Allessandro, Chesapeake Employers' Insurance
Marian Currens, CRNP

- **Brett Lininger**: Workers' comp is a very small space, but this issue is raging in it. Kentucky passed mandatory querying in 2012 and saw an 8.5% decrease – the first decrease in 10 years. Ohio went to mandatory use and in its first year prescribing practices were changed. 61% prescribed fewer opioids. New York saw a decrease of patients seeking multiple doctors, as well as in Tennessee, who also saw a 1 million pill decrease. This does work. Maryland is not the only state with a heroin and opioid task force. Connecticut has one as well and recommended mandatory use and query of PDMP. Chesapeake supported House Bill 3. The latest draft is more tailored.
- **Marian Currens, Nurse Practitioner Center for Addiction Medicine**: Started PDMP. Needed help to do it. The mandate will help me make staff accept use of PDMP. We've been using PDMP and it's been a help to coordinate care and collaborate. It's been impressive. I want to expand and to have training to continue; make sure that all OTPs are part of this collaborative understanding.
    - **Lt. Governor**: What do you do when you are surprised at what you see?
    - **Ms. Currens**: I use it as a way to work together and figure out what's going on.
    - **Lt. Governor**: Have you found where a person still has a problem but they're getting supplements of medication?
    - **Ms. Currens**: 20% of patients we are working with right now – with medication we did not anticipate. We give them the opportunity to improve on their own. "That query should not be there next time." We work very tightly with them and see them every day.

PANEL 2 - PHYSICIAN AND HOSPITAL PERSPECTIVE

Pam Metz Kasemeyer, counsel
Dr. Steve Daviss – psychiatrist
Dr. Gary Pushkin – orthopedic surgeon and legislative chair of MedChi

Dr. William Jacquis – ED physician and current President of Maryland ACEP
Sheena Siddiqui - Maryland Hospital Association
Nicki McCann – Hopkins
Bob Enten, CVS Health

- **Pam Metz Kasemeyer**: Concerned that jumping to mandatory use before a lot of other system development issues could lead to a counterproductive tool that implodes. Must make sure system is working well and not jump ahead. We must build the system first before mandatory query. When we do get to that point, be careful in how you structure and decide what is legitimately appropriate. Make sure everyone is using it first too. Once system issues are fixed, they will want to use it.
- **Dr. William Jacquis**: Big fans of CRISP and PDMP. We do not have backgrounds of the people we see routinely in the ER. Evolution has been good. We have been involved from the outset. Registration process – we use scribes quite a bit. If we can pass some things to scribes, that would be great. CDS process has to be fixed so we can go to mandatory registration and use. It is flawed right now. Need streamlined workflow. I have 20 people waiting to see me most times. Single sign-ons is good.
- **Dr. Gary Pushkin**: I am a registered CRISP user. I get great information on there but it's not ready. A lot of patients lie to me about their drug use. If someone is a Methadone user I can't see that in the system. That information is protected. We need accessibility. Until the system is ready, we shouldn't be forced to go on there because it would take us away from our patients. I have to log in, then put in secondary password. Then I type in the client name and birth date. It's tedious. The system is not ready for us.
    - **Lt. Governor**: If we do roll it out, we will roll it out in phases so it will be ready. We are hearing that 70-80% of heroin users are coming off prescriptions so we have to address that. PDMP is really informational and is meant to help you rather than to say you have to stop prescribing.
    - **Dr. Pushkin**: The mandatory aspect is the problem. The system is not ready to handle us. It has to work better first.
    - **Lt. Governor**: We will look at those things. I do resent relating it to health exchange. It did not go through the procurement process.
- **Dr. Steve Daviss**: a lot of us practice at multiple locations, and CRISP does not have the capability to have multiple locations. Single sign-on integrating with EHR is important. Let's focus on just the opiates. Mandated use must be limited and not with every single time you prescribe. Maybe there should be a way to compare with peers (other doctors). There's no way to flag inaccuracies – I want to just click and say I think this is wrong. Watch out when people can't get heroin anymore: there will be a spike in heroin deaths because they'll get it on the street, not know how to use it and die.
- **Nicki McCann**: If someone is in a treatment program, that information cannot be entered into PDMP because of federal law. With HIPAA you can share data, but with a separate consent form. Every level of sharing needs separate consent. PDMP intends to capture a lot of overprescribing but will never capture in-treatment program. A query would not capture this.
    - **Lt. Governor**: Can we at the state level put restrictions/requirements for Methadone patients to sign waiver?
    - **Ms. McCann**: No, because of federal law. Changes of federal law also needed.

- **Sheena Siddiqi**: One of our efforts is to standardize opiate prescribing practices – we worked on this this past summer. Opiate prescribing guidelines. One of the recommendations is that emergency providers are encouraged to consult PDMP before writing prescriptions. Work with DHMH on how to access/register PDMP. We're interested in working with everyone to really develop a workable tool for Maryland's providers.
- **Robert Enten**: There are 172 CVS stores in Maryland that fill 17 million plus prescriptions a year. There is a difference on this issue between those who prescribe and those who dispense. We don't have any other contact except for a person that has a prescription paper and wants to fill it. Our company is concerned about this. We have developed red flags and our pharmacists are trained to use this system to decide whether they should fill the prescription or not. We look at whether the patient is treated by multiple prescribers. Are they impaired when they walk in? Asking for drugs by color/trade name/markings? Unfamiliar with prescriber? Having to check the list per person is problematic. We try to fill as best we can. We are registered on the system and already report after the fact and do best to screen. Mandatory queries is a concern. I have a concern about making you or I wait a long time.
    - **Lt. Governor**: What do you do with the checklist – with the red flag information?
    - **Mr. Enten**: I will have to check on this.
    - **Lt. Governor**: Does a pharmacist have the discretion to deny a prescription if i.e. someone is impaired?
    - **Mr. Enten:** Yes.
    - **Lt. Governor**: The procedure at getting prescription opiates right now isn't good. Maybe the pharmacist needs to come out from behind the counter if it's an opiate prescription to explain what it is.
    - **Nancy Dudley**: Maybe put a red card that would alert someone that it has an addictive potential.
    - **Mr. Enten**: We're a national company and making a system just for Maryland is a big issue.

- The **Lt. Governor** ended the meeting by welcoming additional comments if there are any.